### DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

June 12, 2012

Ms. Judy Morton, Administrator Mountain View Center Genesis Healthcare 9 Haywood Avenue Rutland, VT 05701

Provider #: 475012

Dear Ms. Morton:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **May 14**, **2012**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS Licensing Chief

PC:ne

Enclosure



PRINTED: 05/22/2012 FORM APPROVED OMB NO. 0938-0391

ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		TIPLE CONSTRUCTION NG	COMPLE	
		475012	,				C 4/ <b>2012</b>
	ROVIDER OR SUPPLIER	ENESIS HEALTHCARE			REET ADDRESS, CITY, STATE, ZIP CODE 9 HAYWOOD AVENUE RUTLAND, VT 05701		
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F 223 SS=D	was conducted by Protection on 5/14/deficiancies identification on 5/14/deficiancies identification on 5/14/deficiancies identification on 5/14/deficiancies identification on the facility must not or physical abuse, involuntary seclusion.  The facility must not or physical abuse, involuntary seclusion.  This REQUIREMED by: Based on staff interfacility failed to ensidentified (Residentiand mental abuse.)  Per review of the facility compliance hotline 3/19/12 involving 6 dining room on Cheplaced an adult briewas soiled with feed Licensed Nursing 6 of the incident.	onsite complaint investigation The Division of Licensing and 12. There were regulatory ed. E)(1)(i) FREE FROM TARY SECLUSION  The right to be free from verbal, and mental abuse, corporal voluntary seclusion.  The time the time that one resident at #1), was free of humiliation The findings include:  The findings include:		223	correction does not constitute admission to any of the allege citations set forth in this statement of deficiency. The Center files this plan of correction as evidence of the	er d 's x 3	4.14.12
	/ / /	DERVSLIPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE	_	(X6) DATE

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 tys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

Facility ID: 475012

If continuation sheet Page 1 of 19

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: ND PLAN OF CORRECTION A. BUILDING B. WING 05/14/2012 475012 STREET ADDRESS, CITY, STATE, ZIP CODE IAME OF PROVIDER OR SUPPLIER 9 HAYWOOD AVENUE MOUNTAIN VIEW CENTER GENESIS HEALTHCARE RUTLAND, VT 05701 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 223 Continued From page 1 F 223 disturbances, anxiety, and senile depressive disorder. Per review of the MDS (Comprehensive Assessment ) dated 2/7/12, Resident #1 had both long and short term memory issues, impaired decision making, continuous inattentive behavior, and physical behaviors occurring daily, other behaviors not directed at others, rejecting care and wandering.. Per interview with a staff RN (RN#1) on 5/14/12 at 9:22 AM, he/she stated that he/she " saw an LNA (LNA#1) laughing and taking a picture with his/her cell phone of Resident #1 wearing an adult brief on his/her head and an RN#2 posing for the picture. RN#1 stated that the brief contained feces. Per RN #1, he/she stated that it " did not register until after the picture was taken that this was wrong. " RN#1 stated that staff should " not be laughing and taking pictures that this was an indignity to Resident #1 and he/she knew that laughing at the resident and taking the picture was abusive to Resident #1. Per interview with a staff RN (RN#2) on 5/14/12 at 9:41 AM, he/she stated that on 3/19/12 he/she was present when Resident #1 was in the dining room with a feces soiled adult brief on his/her head. The RN#2 indicated that he/she was passing medications and saw Resident #1 wandering and picking up things. RN#2 saw the resident near the television and went over to redirect the resident away, since in the past Resident #1 had been known to pull things down onto him/herself. RN#2 stated he/she did not realize that a picture was being taken. RN#2 stated that "Resident #1 does things like wear things on his/her head like towels and we laugh at him/her at times " . RN#2 stated " that it was

PRINTED: 05/22/2012

FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	05/22/2012 APPROVED 0938-0391
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F 223	abusive to the reside could have stopped with getting things of he/she was reprima stop an incident and Per interview with the 5/14/12 at 9:50 AM was in the building occurred but no on midway through 3/2 call from RN#1. The the UM that LNA#1 Resident #1 in the wearing a adult brief head. The UM state RN#2 who posed in LNA#1 who took the and thought the incident that if no pic #1 placed the brief be considered abut the picture was take exploitation. The UM state aware of 2 RN 's a incident. The UM state with the picture was take aware of 2 RN 's a incident. The UM state with the picture was take aware of 2 RN 's a incident. The UM state with the picture was take aware of 2 RN 's a incident. The UM state with the picture was take aware of 2 RN 's a incident.	lent and that RN#2 in hindsight it but he/she was concerned done. "RN#2 stated that anded for dignity, failure to defailure to report an incident.  The UM (Unit Manager) on he/she indicated that he/she at the time the incident in incident incident in incident incident in incident i	. <b>F</b>	223			
	5/14/12 at 10:35 A received a call fror 3/21/12, that some compliance hotline Cherry Tree Lane. all of those involve The Administrator	the facility Administrator on M, he/she stated that he/she in the corporate office on sone had called the corporate regarding the incident on The Administrator stated that d "admitted participation" stated his/her "expectation of not take pictures of residents				·	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 223	without their perm not have been joki. The Administrator cognition of Reside idea the incident of	age 3 ission and that LNA#1 should ng and not taking pictures. " stated that " due to the ent #1, that Resident #1 had no ccurred and there was no harm at it was not abuse."	F2	223				
	AM, he/she stated this was a respect specific concern we the staff did not sto and laughing at it. '10:35 AM, the DNS abuse, that Reside	he DNS on 5/14/12 at 10:35 that his/her concern was that and dignity issue, and his/her as that a picture was taken and up the incident from occurring Per interview on 5/14/12 at 3 stated that this was not at #1 was not interviewable ction of the incident occurring sing."						
	11:43 AM, he/she i done on abuse pro	he Administrator on 5/14/12 at ndicated that the education hibition on 3/30/12 was done on reporting and not because ed. "						
F 225 SS=D	on 5/14/12 titled; Al indicates that "Abus (including unneces	(c)(2) - (4) PORT	F 2	25				
	been found guilty of mistreating residen	t employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide						

Facility ID: 475012

FORM CMS-2567(02-99) Previous Versions Obsolete

#### PRINTED: 05/22/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 05/14/2012 475012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9 HAYWOOD AVENUE MOUNTAIN VIEW CENTER GENESIS HEALTHCARE RUTLAND, VT 05701 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 Continued From page 4 F 225 F225 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; Resident #1 is stable and the center and report any knowledge it has of actions by a has not seen any changes in mood court of law against an employee, which would or behavior from incident. indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry Involved staff received disciplinary or licensing authorities. action on 3/22/12 The facility must ensure that all alleged violations 6-14-12 center staff will receive involving mistreatment, neglect, or abuse, education regarding abuse and including injuries of unknown source and reporting misappropriation of resident property are reported immediately to the administrator of the facility and Center to audit cases of suspected to other officials in accordance with State law abuse for timely reporting monthly through established procedures (including to the State survey and certification agency). The results of these audits will be reported by the Administrator to The facility must have evidence that all alleged the CQI Committee. The CQI violations are thoroughly investigated, and must Committee will evaluate for further prevent further potential abuse while the recommendations. investigation is in progress. F225 POC accepted 6/12/12 The results of all investigations must be reported to the administrator or his designated meuhanen Protuen representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced

Based on staff interview and record review the facility failed to ensure that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the Administrator of the

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at 9:22 AM, he/she stated that he/she " saw an LNA (LNA#1) laughing and taking a picture with his/her cell phone of Resident #1 wearing an adult brief on his/her head and an RN#2 posing for the picture. RN#1 stated that the brief

contained feces. Per RN #1, he/she stated that it "did not register until after the picture was taken that this was wrong. "RN#1 stated that staff should "not be laughing and taking pictures that

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F 225	knew that laughing picture was abusive that he/she called next day(3/20/12) at the incident becaused abuse, but it again. "Per RNA he/she did not call compliance hotlines the incident.  Per interview with at 9:41 AM, he/she was present when room with a feces head. The RN#2 in passing medication wandering and pict resident near the teredirect the resider Resident #1 had be onto him/herself. Frealize that a pictur stated that "Resident him/her at times" abusive to the resident him/her at times abusive to the resident he/she was reprim failure to stop an ir incident.  Per interview with he/she indicated the he/she	age 6  ty to Resident #1 and he/she at the resident and taking the e to Resident #1. RN#1 stated the Unit Manager (UM) the and asked the UM not to report se RN#1 " did not want to get e, that it was a mistake that was sure staff would never do e1, he/she indicated that Administration, the corporate or any state agency to report  a staff RN (RN#2) on 5/14/12 e stated that on 3/19/12 he/she Resident #1 was in the dining soiled adult brief on his/her dicated that he/she was as and saw Resident #1 king up things. RN#2 saw the elevision and went over to at away, since in the past een known to pull things down en known to pull things down en was being taken. RN#2 lent #1 does things like wear ead like towels and we laugh at RN#2 stated " that it was dent and that RN#2 in hindsight d it but he/she was concerned done. " RN#2 stated that anded after 3/21/12 for dignity, acident and failure to report an ethe UM on 5/14/12 at 9:50 AM, that he/she was in the building at an toccurred on 3/19/12 but no	F	225			
	Eczyna no) Provinus Version	s Obsolete Event ID: GG7711		Facil	ity ID: 475012 If contin	nuation sheet	Page 7 of 19

#### PRINTED: 05/22/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 475012 05/14/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9 HAYWOOD AVENUE MOUNTAIN VIEW CENTER GENESIS HEALTHCARE RUTLAND, VT 05701 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLÉTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 Continued From page 7 one informed him/her until midway through 3/20/12 when the UM received a call from RN#1. The UM stated that RN#1 told the UM that LNA#1 had taken a picture of Resident #1 in the dining room on 3/19/12 wearing a adult brief soiled with feces on his/her head. The UM stated that he/she spoke to the RN#2 who posed in the picture and spoke to the LNA#1 who took the picture and was laughing and thought the incident was funny, The UM stated it was a " lapse in judgment " . The UM stated that if no picture was taken after Resident #1 placed the brief on his/her head then it would not be considered abuse, that it became abuse when the picture was taken and could be considered exploitation. The UM indicated that he /she was aware of 2 RN 's and 2 LNA 's involved in the incident. The UM stated that he/she has faith in his/her staff that they are doing the right thing. " The UM stated that he/she had been reprimanded after 3/21/12 for not reporting the incident." Per interview with the facility Administrator on 5/14/12 at 10:35 AM, he/she stated that he/she received a call from the corporate office on 3/21/12, that someone had called the corporate compliance hotline regarding the incident on Cherry Tree Lane. The Administrator stated that all of those involved "admitted participation". The Administrator stated his/her "expectation of

staff was that they not take pictures of residents without their permission and that LNA#1 should not have been joking and not taking pictures. "

Per interview with the DNS on 5/14/12 at 10:35 AM, he/she stated that his/her concern was that this was a respect and dignity issue, and his/her specific concern was that a picture was taken and

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F 225	the staff did not sto and laughing at it. expectation is that report to a supervi	age 8 op the incident from occurring " The DNS stated his/her staff protect the resident then sor, Administration or the they are comfortable reporting	F2	225			-
	Administrator state terminated for "ta without permission RN#2 was reprima" not supervising the incident from occuthe UM was reprimated.	14/12 at 10:35 AM, the ed that the LNA#1 was king a picture of a resident a. The Administrator stated that anded with a written warning for the LNA and stopping the rring". The Administrator stated that handed for not informing the irector of Nursing (DNS) about					•
	11:43 AM, he/she done on abuse pro	the Administrator on 5/14/12 at indicated that the education whibition on 3/30/12 was done on reporting and not because red. "					
	indicated the UM w comply with policie HIPAA, abuse and a recent event on C LNA took a picture and when the situa UM, he/she did not DNS aware so that	employee files on 5/14/12 vas reprimanded for "failing to s regarding resident rights, neglect reporting surrounding Cherry Tree Lane where an of a resident on his/her cell, ation was made aware to the make Administration or the proper action could be taken elay in reporting to appropriate	•				
		acility reportable events 12, the document states;					

#### PRINTED: 05/22/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** ND PLAN OF CORRECTION A. BUILDING B. WING 05/14/2012 475012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9 HAYWOOD AVENUE MOUNTAIN VIEW CENTER GENESIS HEALTHCARE RUTLAND, VT 05701 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 Continued From page 9 F 225 "Reporting incidences of abuse and neglect is your professional and moral duty." 483.15(a) DIGNITY AND RESPECT OF F 241 F 241 SS=D INDIVIDUALITY Resident #1 is currently stable and the center has not seen any changes The facility must promote care for residents in a in mood or behavior from incident. manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Center staff will receive education regarding abuse, reporting and resident dignity. This REQUIREMENT is not met as evidenced bý: Based on staff interview and record review the facility failed to ensure for one resident (Resident Center to audit cases of suspected #1), that care iwas provided in a manner and in abuse for timely reporting monthly an environment that maintains or enhances each x 3. The results of these audits will resident's dignity and respect in full recognition of be reported by the Administrator to his/her individuality. The findings include: the CQI Committee. The CQI Committee will evaluate for further Per review of the facility's internal investigation recommendations

of the incident

on 5/14/12, the investigation indicated that on 3/21/12 the facility was notified by the corporate

compliance hotline that an incident occurred on

Per record review on 5/14/12, Resident #1 was admitted to the facility on 12/23/10 with diagnosis

disturbances, anxiety, and senile depressive disorder. Per review of the MDS (Comprehensive Assessment) dated 2/7/12, Resident #1 had both long and short term memory issues, impaired

that include; dementia with behavior

3/19/12 involving Resident #1, who was in the dining room on Cherry Tree Lane at 8:00 AM and placed a adult brief (incontinence product) that was soiled with feces on his/her head and an Licensed Nursing Assistant(LNA)t took a picture

Fa41 POC accepted 6/12/12

M Culihan RN OMCOTURN

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 241	decision making, cophysical behaviors not direct and wandering.  Per interview with a at 9:22 AM, he/she LNA (LNA#1) laugh his/her cell phone cadult brief on his/her for the picture. RN# contained feces. Per did not register unthat this was wrong should " not be lauthis was an indignite."	ontinued From page 10 ecision making, continuous inattentive behavior, hysical behaviors occurring daily, other ehaviors not directed at others, rejecting care and wandering.  er interview with a staff RN (RN#1) on 5/14/12 9:22 AM, he/she stated that he/she "saw an NA (LNA#1) laughing and taking a picture with s/her cell phone of Resident #1 wearing an dult brief on his/her head and an RN#2 posing r the picture. RN#1 stated that the brief entained feces. Per RN #1, he/she stated that it did not register until after the picture was taken at this was wrong. "RN#1 stated that staff hould "not be laughing and taking pictures that is was an indignity to Resident #1 and he/she new that laughing at the resident and taking the		241			
	at 9:41 AM, he/she was present when it room with a feces is head. The RN#2 incompassing medication wandering and pick resident near the teredirect the resident Resident #1 had be onto him/herself. Rivealize that a picture stated that "Resident things on his/her he him/her at times" abusive to the resident ould have stopped with getting things of	staff RN (RN#2) on 5/14/12 stated that on 3/19/12 he/she Resident #1 was in the dining soiled adult brief on his/her dicated that he/she was s and saw Resident #1 ting up things. RN#2 saw the elevision and went over to at away, since in the past een known to pull things down N#2 stated he/she did not e was being taken. RN#2 eent #1 does things like wear ead like towels and we laugh at RN#2 stated " that it was lent and that RN#2 in hindsight it but he/she was concerned done. " he UM ( Unit Manager) on					

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	ROVIDER OR SUPPLIER	ENESIS HEALTHCARE		9	REET ADDRESS, CITY, STATE, ZIP CODE HAYWOOD AVENUE RUTLAND, VT 05701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	the UM that LNA#1 Resident #1 in the of wearing a adult brishead. The UM state RN#2 who posed in LNA#1 who took the and thought the incited it was a "lay stated that if no picited the brief be considered abust the picture was take exploitation. The UI aware of 2 RN 's a incident. The UM stated that the Per interview with the 5/14/12 at 10:35 AN received a call from 3/21/12, that some compliance hotline Cherry Tree Lane. all of those involved The Administrator's staff was that they without their permish not have been joking The Administrator's cognition of Reside idea the incident or resident that it was Per interview with the staff was that they without their permish that it was the permished incident or resident that it was the properties of the properties with the permished incident or resident that it was the properties with the permished incident that it was the properties with the permished incident or resident that it was the properties with the properties	he/she stated that RN#1 told had taken a picture of dining room on 3/19/12 of soiled with feces on his/her ed that he/she spoke to the at the picture and spoke to the editor and was laughing ident was funny, The UM core in judgment ". The UM core was taken after Resident on her head then it would not be, that it became abuse when en and could be considered of indicated that he/she was and 2 LNA's involved in the lated that he/she has faith in each at the dining the right thing."  The facility Administrator on of the Administrator stated that it admitted participation ". It is admitted participation to take pictures of residents are and not taking pictures."  Stated that "due to the int #1, that Resident #1 had no courred, there was no harm to	F	241			
	this was a respect a	and dignity issue, and his/her				٠	

Facility ID: 475012

specific concern was that a picture was taken and

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(X3) DATE SURVEY

TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		475012	B. WI	NG _		1	C 4/2012
	ROVIDER OR SUPPLIER	ENESIS HEALTHCARE		9	REET ADDRESS, CITY, STATE, ZIP CODE HAYWOOD AVENUE RUTLAND, VT 05701		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) · COMPLETION DATE
F 241	and laughing at it. " expectation is that sereport to a supervise hotline or any one to to." Per interview DNS stated that this #1 was not interview of the incident occur. Per interview on 5/1 Administrator stated terminated for "tak without permission. RN#2 was reprimar "not supervising the incident from occur the UM was reprimar Administrator or Dir the incident.  Per review of the er indicated the UM was reprimared to the unique to the eriodicated the UM was reprimared to the unique to the eriodicated the UM was reprimared to the unique to	p the incident from occurring The DNS stated his/her staff protect the resident then or, Administration or the hey are comfortable reporting on 5/14/12 at 10:35 AM, the s was not abuse, that Resident w able and had no recollection rring when asked in passing."  14/12 at 10:35 AM, the d that the LNA#1 was sing a picture of a resident The Administrator stated that nded with a written warning for e LNA and stopping the ring. The Administrator stated anded for not informing the rector of Nursing (DNS) about mployee files on 5/14/12 as reprimanded for "failing to					
F 250 SS=D	HIPAA, abuse and a recent even on Citook a picture of a rwhen the situation whe/she did not mak aware so that properesulted in a delay in agencies. " 483.15(g)(1) PROV RELATED SOCIAL		F:	250			
	services to attain or	ovide medically-related social maintain the highest I, mental, and psychosocial				,	
DDM CMS 25	667(02-99) Previous Versions	Obsolete Event ID: GG771	1	Fa	cility ID: 475012 If contin	uation sheet F	Page 13 of 19

PRINTED: 05/22/2012

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED . 0938-0391
TATEMENT	S FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '	IULTIPI	LE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ETED
		475012	B. WIN	NG		1	C 4/2012
	ROVIDER OR SUPPLIER	ENESIS HEALTHCARE		9 H	EET ADDRESS, CITY, STATE, ZIP CODE HAYWOOD AVENUE  JTLAND, VT 05701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	Continued From pa well-being of each		F2	250	F250 Resident #1 is stable and the contains not seen any changes in more or behavior from incident		
	by: Based on staff interfacility failed to provide to attain or practicable physical	NT is not met as evidenced erview and record review the vide medically-related social r maintain the highest al, mental and psychosocial resident identified (Resident iclude:			Social workers to review cases reported abuse to determine if residents were affected.  Social workers will be educated updating care plans for resident with psychosocial needs.	other d on	6-14-12
	5/14/12, the invest 3/21/12 the facility compliance hotline 3/19/12 involving R dining room on Cheplaced a adult brief was soiled with fec	acility's internal investigation on igation indicated that on was notified by the corporate that an incident occurred on esident #1, who was in the erry Tree Lane at 8:00 AM and incontinence product) that es on his/her head and an Assistant(LNA)t took a picture			Care plans for patients who have reported cases of abuse will be audited monthly x 3.  The results of these audits will reported by the Administrator to the CQI Committee. The CQI Committee will evaluate for fur recommendations  Oversight: Administrator	be o	
·	admitted to the factor that include; demed disturbances, anxious disorder. Per review Assessment ) date long and short term decision making, c	on 5/14/12, Resident #1 was ility on 12/23/10 with diagnoses ntia with behavior ety, and senile depressive w of the MDS (Comprehensive d 2/7/12, Resident #1 had both n memory issues, impaired ontinuous inattentive behavior, occurring daily, other			Faso Poc accepted 6/12/12 Mculinan RN/ Amcotarn		

Facility ID: 475012

behaviors not directed at others, rejecting care and wandering. Per record review on 5/14/12, there was no evidence that Social Services met

with Resident #1 and assessed the potential effects of the incident of staff laughing and taking

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R WING 05/14/2012 475012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9 HAYWOOD AVENUE MOUNTAIN VIEW CENTER GENESIS HEALTHCARE RUTLAND, VT 05701 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 250 F 250 Continued From page 14 pictures of Resident #1 when the resident placed a feces soiled adult brief on his/her head in the dining room at 8:00 AM on 3/19/12. Per record review there was no evidence that Social Services assessed Resident #1 after the incident on 3/19/12 to assess for potential needs of Resident #1. Per review of Resident #1's medical record on 5/14/12 there was no evidance that the incident on 3/19/12 had occurred and there was no evidance that a plan was discussed or created to prevent Resident #1 from being the victim of future abuse. Per review on 5/14/12 of the comprehensive care plan last revised on 4/26/12 there was no evidance that the care plan was revised to reflect the resident's current status of being a victim of abuse and no reflection of any goals or interventions to prevent reoccurance of abusive actions by others towards Resident #1. Per interview with the Social Service Worker on 5/14/12 at 12:17 PM, he/she stated that he/she "was made aware of the picture being taken by staff through hearsay and the incident was discussed at morning meeting that pictures should not be taken of residents." The Social Service Worker stated that he/she "did not meet with the resident" after the event occurred. F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO F 280 PARTICIPATE PLANNING CARE-REVISE CP SS=D The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

PRINTED: 05/22/2012 FORM APPROVED OMB NO. 0938-0391

TATEMEN ON PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPLI	
(ND ) D (IV C	,, CO,,,,,,,,,	475012	B. WING _		1	C <b>4/2012</b>
	PROVIDER OR SUPPLIER	ENESIS HEALTHCARE	9	REET ADDRESS, CITY, STATE, ZIP CODE HAYWOOD AVENUE RUTLAND, VT 05701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	A comprehensive of within 7 days after to comprehensive assinterdisciplinary teal physician, a register for the resident, and disciplines as deter and, to the extent puther resident, the resident, the resident representative.	ge 15 are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 280	F280 Resident #1 is currently stable the center has not seen any ch in mood or behavior from incidents workers to review case reported abuse to determine if residents were affected.  Social workers to be educated regarding updating care plans residents with psychosocial necessity.	anges ident. s of fother for	6.14.12
	by: Based on staff interfacility failed to reviplan for one resider reflect the actual mand the intervention potential incidences include:  Per review of the fas/14/12, the invest 3/21/12 the facility compliance hotline 3/19/12 involving R dining room on Cheplaced a adult brief was soiled with fec Licensed Nursing A of the incident	erview and record review the se the comprehensive care not identified (Resident #1) to ental abuse of the resident and goals to prevent future of abuse. The findings excility's internal investigation on igation indicated that on was notified by the corporate that an incident occurred on esident #1, who was in the erry Tree Lane at 8:00 AM and (incontinence product) that es on his/her head and an assistant(LNA)t took a picture on 5/14/12, Resident #1 was		Care plans for patients who have reported cases of abuse will be audited and reviewed monthly.  The results of these audits will reported by the Administrator the CQI Committee. The CQI Committee will evaluate for for recommendations.  Oversight: Administrator  Fabo for accepted 6/12/12  Manner A Amministrator	e y x 3.  l be to	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE S COMPLI	
		475012	B. WIN			1	C <b>4/2012</b>
	PROVIDER OR SUPPLIER  TAIN VIEW CENTER GENESIS HEALTHCARE			9 F	EET ADDRESS, CITY, STATE, ZIP COE HAYWOOD AVENUE JTLAND, VT 05701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	that include; demendisturbances, anxied disorder. Per review Assessment ) date long and short term decision making, cophysical behaviors behaviors not direct and wandering.  Per interview with a at 9:22AM, he/she LNA (LNA#1) laugh his/her cell phone cadult brief on his/hefor the picture. RN# contained feces. Per did not register ur that this was wrong should " not be lauthis was an indignit knew that laughing picture was abusive Per interview with at 9:41 AM, he/she	lity on 12/23/10 with diagnoses natia with behavior ety, and senile depressive of the MDS (Comprehensive d 2/7/12, Resident #1 had both a memory issues, impaired ontinuous inattentive behavior, occurring daily, other sted at others, rejecting care a staff RN (RN#1) on 5/14/12 stated that he/she "saw an ning and taking a picture with of Resident #1 wearing an er head and an RN#2 posing et 1 stated that the brief er RN #1, he/she stated that it it after the picture was taken in "RN#1 stated that staff ghing and taking pictures that y to Resident #1 and he/she at the resident and taking the	F 2	80			
	room with a feces shead. The RN#2 in passing medication wandering and pick resident near the teredirect the resider Resident #1 had be onto him/herself. Realize that a pictur	soiled adult brief on his/her dicated that he/she was as and saw Resident #1 king up things. RN#2 saw the elevision and went over to at away, since in the past een known to pull things down N#2 stated he/she did not be was being taken. RN#2 ent #1 does things like wear					

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SL COMPLE	
		475012	B. WI			05/14	2 1/2012
	ROVIDER OR SUPPLIER	ENESIS HEALTHCARE		9	REET ADDRESS, CITY, STATE, ZIP CODE HAYWOOD AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	him/her at times ". abusive to the reside could have stopped with getting things of the could have stopped with getting things of the UM that LNA#1 Resident #1 in the wearing an adult brhead. The UM state RN#2 who posed in LNA#1 who took the and thought the incited it was a " last stated that if no pic #1 placed the brief be considered abust the picture was take exploitation. The Umaware of 2 RN's a incident. The UM sincident.	ead like towels and we laugh at RN#2 stated " that it was lent and that RN#2 in hindsight it but he/she was concerned	Fí	280			
	received a call from 3/21/12, that some compliance hotline Cherry Tree Lane. all of those involved The Administrator staff was that they without there perm not have been joking The Administrators.	the corporate office on one had called the corporate regarding the incident on The Administrator stated that d' "admitted participation " stated his/her "expectation of not take pictures of residents assion and that LNA#1 should ag and not taking pictures. " stated that " due to the nt #1, that Resident #1 had no					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			C 05/14/2012	
	475012						
	ROVIDER OR SUPPLIER	ENESIS HEALTHCARE		9	REET ADDRESS, CITY, STATE, ZIP CODE 9 HAYWOOD AVENUE RUTLAND, VT 05701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTI		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ON SHOULD BE COMPLETION DATE	
F 280	Per interview with AM, he/she stated this was a respect specific concern with staff did not store and laughing at it. expectation is that report to a supervitable. AM, the DNS abuse, that Reside and had no recolle when asked in passible. Per review of Resident and had no recolle when asked in passible. Per review of Resident and the prevent Resident and prevent Resident Re	the DNS on 5/14/12 at 10:35 that his/her concern was that and dignity issue, and his/her as that a picture was taken and op the incident from occurring "The DNS stated his/her staff protect the resident then sor, Per interview on 5/14/12 at 6 stated that this was not ent #1 was not interview able ction of the incident occurring	F	280			